



Applicant Information:					
Last Name:		First Name:			MI:
Home Address (<i>number, street, P. O. Box</i>):					
City:			State:	9 Digit Zip Code:	
Social Security Number:	Home Phone Number: (Including area code) ()		Date of Birth: (mm/dd/yyyy)		
Category of Permit or License:					
Select one category of Permit or License (<i>check one box only</i>)					
PERMIT:					
<input type="checkbox"/> Student Radiography		<input type="checkbox"/> Student Nuclear Medicine		<input type="checkbox"/> Provisional Radiography	
<input type="checkbox"/> Student Radiation Therapy		<input type="checkbox"/> Student Dental Radiography			
LICENSE:					
<input type="checkbox"/> Limited Chest		<input type="checkbox"/> Limited Dental		<input type="checkbox"/> Limited Podiatric	
<input type="checkbox"/> Limited Chiropractic		<input type="checkbox"/> Limited Cardiac Catheterization		<input type="checkbox"/> Radiation Therapy	
<input type="checkbox"/> Radiologic Technologist		<input type="checkbox"/> Nuclear Medicine Technologist			
High School Education Information					
Have you graduated from high school? If yes, indicate the date: Yes or No ____ / ____ / ____ (mm / dd / yyyy)		If G.E.D., give number and date:		High school: _____ Location: _____	
Approved Educational Program:					
Name of School:	Location of School:		Date Enrolled (mm/dd/yyyy):	Date Graduated or Projected to Graduate: (mm/dd/yyyy)	

Professional Information: (License only)

Check appropriate professional examination/certification you have completed (*if any*):

☐ ARRT Radiography
Certification

☐ ARRT Limited Scope
Examination

☐ DANB Certified Dental
Assistant

☐ DANB Dental Radiation Health and
Safety Examination

☐ NMTCB Nuclear
Medicine

☐ ARRT Radiation Therapy
Certification

Compliance Information:

Answer each of the following questions “Yes” or “No”. If you answer any of the questions “Yes”, please provide a complete explanation on a separate sheet.

Have you ever been convicted of a felony? _____ ☐ Yes ☐ No

Have you ever been denied or had a license/certification revoked? _____ ☐ Yes ☐ No

Have you ever been formally notified of any complaint against you relative _____ ☐ Yes ☐ No
to the practice of radiologic technology?

Do you have a drug or an alcohol abuse problem or any mental or physical
disability that, through the practice of your duties, may be dangerous _____ ☐ Yes ☐ No
to patients or public?

Applicant Agreement:

In consideration of the granting to me a permit/license, I do hereby agree to abide by all the rules and regulations of the Indiana State Department of Health, and to permit the Department, or its duly authorized representative, at all reasonable times, opportunity to inspect my permit/license.

I also declare, subject to the penalties for perjury, that all data appearing on this application is accurate and true to the best of my knowledge. I hereby authorize the release of any and all educational information concerning this application to the Indiana State Department of Health.

Signature of Applicant: _____ Date Signed: _____
(mm/dd/yyyy)

BEFORE YOU MAIL YOUR APPLICATION:

1. Have all questions been answered?
2. Is your application signed?
3. Have you enclosed your license fee?
4. If your name has changed since you enrolled in a radiography program, enclose a copy of your proof of name change (copy of marriage certificate, divorce decree, or court order stating the legal name change).